

MONTANA BOARD OF NURSING
P. O. Box 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513

www.nurse.mt.gov

Phone Contact for Examination Applicants:

(406) 841-2397

e-mail: dlibsdnur@mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

Application Fees must be paid before your application can be reviewed.

(Please allow 10 days for processing from the date that the Board has a complete routine application.)

NURSES ARE NOT PERMITTED TO PRACTICE MEDICINE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE. **To safeguard life and health, a person practicing or offering to practice professional nursing or practical nursing in this state shall be required to submit evidence that the person is qualified to practice and is licensed by the Board. [37-8-101 MCA]**

THE FOLLOWING INSTRUCTIONS APPLY TO ALL APPLICANTS:

- A valid Social Security Number is required to submit an application. Applications will not be accepted without a valid Social Security Number.
- Photocopies or faxed copies of the application or transcripts will **NOT** be accepted. We must have the original documents sent directly to our office.

▪ **FEES:**

Licensure by Examination: \$100.00. Please enclose a check or money order made payable to Montana Board of Nursing. Optionally, you may pay by credit-card or electronic check (please see the credit card payment form which is included in this application). The Board retains the application fee even if your application is withdrawn or denied. The fee must be included with the application to ensure processing. **If a temporary permit is requested you must include an additional \$25.00.**

▪ **PHOTOS:**

A passport-size photograph (2" by 2") must be attached to the front page of the application. Please do not use photocopied photographs.

▪ **NOTARIZATION:**

Your application must be notarized by a notary public before it is submitted. Applications without a notary seal or stamp will be returned.

▪ **EDUCATION REQUIREMENTS:**

Applicants shall have completed all educational requirements of an approved nursing education program. [37-8-405 and 37-8-415 MCA].

▪ **OFFICIAL TRANSCRIPTS:**

It is the applicant's responsibility to request that official transcripts from the school where an approved nursing education program was completed be sent directly to the Montana Board of Nursing. This may be done prior to making application with the Board. Photocopies or unofficial transcripts do not qualify as official verification of completing the approved nursing education program. Transcripts must be official and must be received directly from the school.

▪ **EXAMINATION INFORMATION:**

The applicant must register with PearsonVue in order to take the NCLEX. (Contact PearsonVue online at <http://www.pearsonvue.com/nclex> or call toll-free 1-866-496-2539.) Applicant must receive a passing score on the National Council of State Boards of Nursing (NCLEX) exam prior to licensure. [ARM 24.159.1418] If the applicant fails the NCLEX their temporary permit (if issued) is immediately revoked. The applicant may retake the exam after 45 days. If the applicant wishes to retake the NCLEX, a new application along with applicable fees must be submitted and the applicant must register with PearsonVue again. If the applicant does not pass the retake, a plan of study must be presented to the board before being approved to retake the exam again. An applicant may take the exam a maximum of five times in three years. If an applicant does not pass the exam within three years, the applicant must complete a school of nursing program before being able to test a sixth time.

▪ **TEMPORARY PERMIT:**

Applicants may apply for a 90-day temporary permit. Temporary Permits are only given to applicants who are taking the exam for the first time. They must complete the Temporary Permit application, including a signature from a supervising RN. There is an additional \$25 application fee for a temporary permit.

▪ **RENEWAL**

ALL LICENSES EXPIRE ON 12/31 OF EVEN YEARS REGARDLESS OF THE YEAR OF ISSUANCE.
RENEWAL NOTICES ARE MAILED IN OCTOBER OF THE EVEN YEARS. PLEASE READ YOUR PERMANENT
LICENSE CLOSELY FOR DATES AND ACCURACY OF INFORMATION!

IMPORTANT INFORMATION FOR ALL APPLICANTS

- The applicant will be notified in writing or by email of any deficient or missing items from the application file. When the application file is complete, if the applicant has registered with PearsonVue, we notify PearsonVue of the applicant's eligibility to test. PearsonVue will then contact the applicant with "Authorization to Test." We receive test results within 48 hours after the applicant has completed the test. Once we receive notification that the applicant has passed the NCLEX, a permanent license will be issued. (You can check on the status of your license online at www.nurse.mt.gov, click on *Licensee Lookup System*.)
- Keep the Board office informed at all times of any name or address changes, changes in license status, and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

NON -ROUTINE APPLICATIONS

If the completed application is considered a non-routine application, there may be a delay in the processing of the application. Non-routine applications include those who have had previous or current licensure discipline or indicate previous or current applicable legal actions. It is critical to your initial and continuing licensure to be completely forthright regarding each question on the application. You must submit the copies of the court/Board documents and findings. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.

For information with regard to the processing of this application or other concerns please contact the Board of Nursing staff at (406) 841-2345 for endorsement applications, or (406) 841-2397 for examination applications, or email us at dlibsdnur@mt.gov.

FOREIGN NURSING SCHOOL GRADUATES

All standard application requirements apply. In addition:

- Please provide a copy of your Social Security card with your application.
- **LPN Applicants:**
 - Provide an official CES (Credentialing Evaluation Service) Healthcare Level course-by-course report. CES reports are obtained through CGFNS. CGFNS can be contacted at www.cgfns.com
3600 Market Street, Suite 400
Philadelphia, PA 19104-2651
USA Applicant Inquiries: (215) 349-8767
 - Provide TOEFL (Test of English as a Foreign Language) scores. TOEFL information can be obtained online at www.ets.org/toefl or by contacting E.T.S. at
P.O. Box 6181
Princeton, NJ 08541-6451
Phone: 1-800-468-6335
(Please use code number **8742** for the score recipient so we receive an official copy of your TOEFL.)
- **RN Applicants:** RN Applicants must obtain a CGFNS (Commission on Graduates of Foreign Nursing Schools) Certificate and have CGFNS send official verification of your certification directly to the Montana Board of Nursing. CGFNS can be contacted at www.cgfns.com
3600 Market Street, Suite 400
Philadelphia, PA 19104-2651
USA Applicant Inquiries: (215) 349-8767
- All nurses previously licensed in Canada, must also provide proof of passing the CNAT exam.

***NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED
BY CERTIFIED TRANSLATIONS.***

If you are a graduate of a foreign nursing school, and still have questions regarding these additional application requirements, please feel free to contact the Board of Nursing licensing staff at (406) 841-2397.

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E-MAIL: dlibsdnur@mt.gov WEBSITE: www.nurse.mt.gov

AFFIX PHOTO
HERE
PASSPORT SIZE

Application for Licensure by Examination as (check one): ☐ **Registered Nurse** ☐ **Practical Nurse**

Temporary Permit Requested: ☐ **No** ☐ **Yes**

Allow 10 days from the date the Board has a complete routine application file to be made eligible to test.

PLEASE PRINT OR TYPE

1. FULL NAME: _____
Last First Middle

Please print your name as you wish it to appear on your license

2. SOCIAL SECURITY NUMBER: _____ 3. GENDER: ☐ Female ☐ Male

4. OTHER NAME(S) KNOWN BY (i.e. maiden name): _____

5. PREFERRED MAILING ADDRESS: _____
Street or PO Box

City State ZIP

6. MAILING ADDRESS is: ☐ Home ☐ Business

7. E-MAIL ADDRESS: _____

8. TELEPHONE (_____) _____ (_____) _____ (_____) _____
Home Cell Fax

9. Date of Birth: _____ 10. Place of Birth: _____
(mm/dd/yyyy) City, State

11. If you are a foreign nursing graduate, have you satisfied the requirements of the Commission on Graduates of Foreign Nursing (CGFNS)? ☐ Yes ☐ No ☐ N/A

12. Do you intend to practice in the State of Montana? ☐ Yes ☐ No

13. Have you ever previously applied for a license to practice in Montana?
(If yes, give date and results: _____) ☐ Yes ☐ No

14. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach an official document. ☐ Yes ☐ No

15. Have you ever withdrawn an application for nursing licensure? If yes, please give the state and reason for withdrawal. ☐ Yes ☐ No

16. PROFESSIONAL EDUCATION

Name of college/university attended: _____

Location of college/university: _____

City

State

Year of completion of approved nursing education program: _____

Type of degree or certificate earned: ☐ **Assoc.** ☐ **Bacc.** ☐ **Diploma** ☐ **Certificate** ☐ **Other:** _____

17. List any nursing licenses that you have previously held (if any). Failure to list any past nursing licenses constitutes a falsification of your application and will result in a declined status of your application and/or disciplinary action.

State	License #	License Type	Issue Date	Expiration Date

18. Has a licensing agency ever taken adverse or disciplinary action against your license? **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No

19. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No

20. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No

21. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No

22. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? **If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations.** ☐ Yes ☐ No

23. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No

24. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No
25. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines of less than \$100 and (2) charges or convictions prior to your 16th birthday. **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No
26. Have you any physical or mental condition which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No
27. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? **(If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.)** ☐ Yes ☐ No

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Nursing. I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice. I understand that, if issued a Montana license, I can receive a copy of the current licensure statutes and rules of the State of Montana as of the date the license is issued. By initialing **one** of the options below I am indicating my preferred media format:

- _____ I prefer to access the current licensure statutes and rules of the State of Montana online via the Montana Board of Nursing website at www.nurse.mt.gov.
- _____ I prefer a CD-ROM version of the current licensure statutes and rules of the State of Montana.
- _____ I prefer a printed copy of the current licensure statutes and rules of the State of Montana.

Legal Signature of Applicant

Date

Subscribed and sworn to before me this _____ day of _____, _____

at _____
City/State

Signature of Notary Public

SEAL

Notary Public Printed Name

For the State of

My commission expires _____, _____.

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TEMPORARY PERMIT APPLICATION AS:

☐ **Registered Nurse** OR ☐ **Practical Nurse** (Please check the correct box.)

Montana Employer Sworn Statement Under Penalty of Perjury

PLEASE PRINT OR TYPE

I, _____ am supervisor of _____
RN Supervisor Name Applicant

with _____ located at
Business Name

Street City State Zip

Phone Number: _____ Extension: _____

I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Print RN Supervisor Name & Title:

RN Supervisor License Number: _____

RN Supervisor Signature: _____

Date: _____

The Applicant and the Board thank you for your assistance.

REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE
(THIS IS NOT AN ENDORSEMENT CERTIFICATION)

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states that do not provide verification through NURSUS. COMPLETE THE LICENSEE INFORMATION SECTION OF THE FORM AND MAIL THE ENTIRE PAGE TO ANY STATE BOARD IN WHICH YOU ARE REQUESTING OFFICIAL LICENSE VERIFICATION BE SENT TO THE MONTANA BOARD. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. BE ADVISED THAT SOME BOARDS REQUIRE A FEE FOR THIS SERVICE. IT IS RECOMMENDED YOU CONTACT THE BOARDS BY PHONE PRIOR TO MAILING IN THIS FORM TO SEE IF YOU NEED TO INCLUDE PAYMENT.

LICENSEE INFORMATION

To Whom It May Concern:

I am applying for a license to practice Nursing in the State of Montana and the Nursing Board requires official license verification. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the:

Montana Board of Nursing, PO Box 200513, Helena MT 59620-0513.

Your prompt response is appreciated.

Name: _____
Please print Signature

Address: _____

My License Number from your state is: _____ License Type: _____

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF NURSING.

LICENSE INFORMATION

Jurisdiction	License type	License Number	Date of licensure	Expiration date	License Status	Basis of Licensure	Date of Initial Licensure

EDUCATION INFORMATION

School Name	Graduation date	Program Code	Degree	City	State

EXAM INFORMATION (if basis of licensure is by exam)

Exam Date	Exam Type	Expiration	# of Attempts

Has license been suspended, revoked, placed on probation or otherwise disciplined?

☐ YES ☐ NO

If YES, please explain and attach documentation.

Has licensee ever been requested to appear before your Board?

☐ YES ☐ NO

If YES, explain: _____

Derogatory information, if any: _____

Comments, if any: _____

Signed: _____ Date

Title: _____

State Board: _____

BOARD SEAL

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VIRTUAL TERMINAL PAYMENT FORM

For this service the Business Standards Division now accepts credit card payments using either Master Card or Visa or an electronic check (**please do not send cash**). You may fill in the appropriate form below to submit payments. **This document will be destroyed after the payment is processed.**

Amount to be billed:

Name of Accountholder: _____
(as it appears on credit card or on printed check)

Address of Accountholder: _____
Street or PO Box

City State Zip

Phone # of Accountholder: _____

Please check method of payment:

☐ **Visa** ☐ **MasterCard**

Credit Card #:

Expiration Date: /

Important: This transaction will appear on your credit card statement as: **Discoveringmontana-SC.**

☐ **E-Check**

Name of Bank: _____

Routing Number: _____

Account Number: _____

Important: This transaction will appear on your bank statement as an electronic transaction with the words: **Montana Interact BSD-VT.**

